

CHILD DEVELOPMENT SERVICES (CDS) REGISTRATION CARD For use of this form, see AR 608-10; the proponent agency is DCSPER	DATE
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DATA REQUIRED BY THE PRIVACY ACT OF 1974

AUTHORITY:	Title 10, United States Code, Section 3013
PRINCIPAL PURPOSE (S):	To provide child and family program eligibility and background information; sponsor consent for access, to emergency medical care; data required by USDA food program.
ROUTINE USES:	Information is furnished the attending physician when it is necessary for a child to be taken to a medical facility by someone other than the parent. Information on immunization and medical problems will be used as part of the program admission screening procedure. Family income data will be used to determine USDA food program qualification and rate structures.
DISCLOSURE:	Disclosure of requested information is voluntary, however, if information is not provided, individuals may not be allowed to participate in CDS programs.

DECLARATION OF NONDISCRIMINATION

Services will be made available to all children in attendance, without regard to race, color, religion, national origin, ancestry, or sex, within the limits of AR 608-10. CDS programs participating in the USDA Food Program shall offer meals without physical segregation of, or discrimination against any child regardless of ability to pay.

NAME OF SPONSOR <i>(Last, first, MI)</i>	GRADE	SSN	SERVICE <i>(Check One)</i> <input type="checkbox"/> ACT <input type="checkbox"/> RET <input type="checkbox"/> CI	SOLE PARENT <input type="checkbox"/> YES <input type="checkbox"/> NO
HOME ADDRESS OF SPONSOR <i>(Include ZIP Code)</i>	ON POST <input type="checkbox"/>	HOME PHONE	DUTY/EMPLOYER ADDRESS <i>(Include ZIP Code)</i>	
	OFF POST <input type="checkbox"/>	DUTY PHONE		
NAME OF SPOUSE <i>(Last, first, MI)</i>	GRADE	SSN	SERVICE <i>(Check One)</i> <input type="checkbox"/> ACT <input type="checkbox"/> RET <input type="checkbox"/> CI	DUAL MILITARY SPONSOR <input type="checkbox"/>
HOME ADDRESS OF SPOUSE <i>(Include ZIP Code)</i>	ON POST <input type="checkbox"/>	HOME PHONE	DUTY/EMPLOYER ADDRESS <i>(Include ZIP Code)</i>	
	OFF POST <input type="checkbox"/>	DUTY PHONE		
EMERGENCY NOTIFICATION DESIGNEE	HOME PHONE	DUTY PHONE	CHILD RELEASE DESIGNEE	
FAMILY SIZE	GROSS INCOME	USDA CATEGORY <i>(Check One)</i> <input type="checkbox"/> FULL <input type="checkbox"/> REDUCED <input type="checkbox"/> PAID	MULTIPLE CHILD DISCOUNT <input type="checkbox"/> FD <input type="checkbox"/> PD <input type="checkbox"/> HR <input type="checkbox"/> FCC <input type="checkbox"/> N/A	

CDS PROGRAM RATES

B/A SCHOOL _____ FULL DAY _____ PRESCHOOL _____ HOURLY _____ FCC HOME _____

NAME OF CHILD (LAST, FIRST, MI)				
DATE OF BIRTH (YYYYMMDD)		SEX	PHYSICAL EXAM DATE (YYYYMMDD)	
IMMUNIZATIONS (YYYYMMDD)				
DTAP 1	DTAP 2	DTAP 3	DTAP 4	DTAP 5
HEP B 1	HEP B 2	HEP B 3	HEP B 4	VARICELLA
HIB 1	HIB 2	HIB 3	HIB 4	TB/PPD
IPV 1	IPV 2	IPV 3	IPV 4	HEP A 1
MMR 1	MMR 2	MMR 3	OTHER	HEP A 2
MEDICAL CONDITIONS:			ALLERGIES:	

SPONSOR CONSENT: I _____ parent/legal guardian of _____ give consent for an authorized CDS representative to take my child for care, medical or dental, in an emergency situation where the child's condition represents a serious or imminent threat to his/her life, health or well being. I understand that a conscientious effort will be made to notify me prior to such action and the expense, if any, will be borne by me. Treatment at an Army medical facility may be provided without additional consent under the provision of AR 40-3, paragraph 2-24b.

DATE	SIGNATURE
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